

Statement of Deficiencies
Citation Summary Sheet

PRINTED: 04/11/2011

For: LAKE COUNTY NURSING & REHABILITATION CENTER (155653 / 000108)
Survey Event: HJ4S12, Exit Date 04/05/2011

Citations Cited This Visit

Regulation Type	Regulation ID	Regulation Version	Building Number	Tag Number	Tag Title	Scope/ Severity
Federal	FF07	12.00	00	0000	INITIAL COMMENTS	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/11/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/05/2011	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on February 15, 2011.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00088266.</p> <p>Survey Dates: April 4 & 5, 2011</p> <p>Facility Number: 000108 Provider Number: 155653 Aim Number: 100267410</p> <p>Survey Team: Lara Richards, R.N., T.C. Heather Tuttle, R.N. (4/4/11) Janet Adams, R.N. (4/4/11) Kathleen Vargas, R.N.</p> <p>Census Bed Type: SNF/NF: 70 TOTAL: 70</p> <p>Census Payor Type: Medicare: 8 Medicaid: 59 Other: 3 Total: 70</p> <p>Sample: 9</p> <p>Lake County Nursing and Rehabilitation was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 Quality review completed 4-8-11 Cathy Emswiller RN			{F 000}			